AMENDED IN ASSEMBLY JUNE 19, 2008

AMENDED IN SENATE MAY 20, 2008

AMENDED IN SENATE APRIL 22, 2008

AMENDED IN SENATE APRIL 10, 2008

## SENATE BILL

No. 1415

## **Introduced by Senator Kuehl**

(Coauthor: Assembly Member Dymally)

February 21, 2008

An act to add Section 123106 to the Health and Safety Code, relating to patient records.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1415, as amended, Kuehl. Patient records: maintenance and storage.

Existing law establishes procedures for providing access to various types of health care records, including patient records, as defined, by patients and persons having responsibility for decisions respecting the health care of others. Existing law gives health care providers, as defined, various responsibilities in connection with providing access to these records.

This bill would require certain health care providers who create patient records, at the time the initial patient record is created, to provide a statement to be signed by the patient, or the patient's representative, that sets forth the patient's rights, as specified, and the intended retention period for the records, as specified in applicable law or by the health care provider's retention policy. The bill would require a copy of the signed statement to be provided to the patient, or the patient's representative, and would also require, if the patient or the patient's

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representative, refuses to sign the statement, that this fact be included in the patient's record.

This bill would require certain health care providers that plan to destroy patient records earlier than the period specified in the signed statement, no fewer than 60 days before a patient's records are to be destroyed, to notify the patient that his or her records are scheduled to be destroyed, when they are scheduled to be destroyed, and set forth the patient's rights, as specified.

This bill would provide that the above provisions shall only apply to patient records created on and a health care provider, as defined, whose first visit with a patient occurs on or after January 1, 2009. It would also provide that the above provisions shall not apply to patients who are minors a health care provider whose patient is a minor at the time the patient record is created.

This bill would provide for the issuance of citations and the assessment of-civil administrative penalties for violation of the bill's requirements, as specified. The bill would exempt the patient records created by a psychiatrist, as defined, from the requirements of the bill.

Vote: majority. Appropriation: no. Fiscal committee: <del>no</del>-yes. State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 123106 is added to the Health and Safety 2 Code, to read:
  - 123106. (a) A health care provider described in paragraphs (4), (5), (6), (8), and (9) of subdivision (a) of Section 123105, who creates patient records, as defined in subdivision (d) of Section 123105, shall, at the time the initial patient record is created, provide a statement to be signed by the patient, or the patient's representative, that sets forth both of the following:
  - (1) The patient's rights under this chapter to inspect his or her medical records, obtain copies of his or her medical records, and dispute incomplete or incorrect items. to provide a written addendum, pursuant to Section 123111, with respect to any item or statement in the patient's records that the patient believes to be incomplete or incorrect.
  - (2) The intended retention period for the records, as specified in applicable law or by the health care provider's retention policy.

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- (b) A copy of the signed statement required pursuant to subdivision (a) shall be provided to the patient.
- (c) If a patient, or the patient's representative, is provided a statement to be signed at the time that the initial patient record is created, and the patient refuses to sign the statement, the patient's record shall indicate that the patient refused to sign.

<del>(b)</del>

- (d) If a health care provider, as defined in subdivision (a), plans to destroy patient records earlier than the period specified in the signed statement, the health care provider shall, no fewer than 60 days before a patient's records are to be destroyed, notify the patient, via first-class mail, electronic mail, or both, to the patient's last known mailing or electronic mail address, or both. The notification shall inform the patient that his or her records are scheduled to be destroyed and the date of the proposed destruction of records. The notification shall also inform the patient of his or her rights under this chapter to inspect his or her medical records and to obtain copies of medical records. Nothing in this subdivision shall be construed to reduce the length of record retention as otherwise required by law.
  - (c) The records of a
- (e) A health care provider, as defined in subdivision (a), shall not be subject to this section for medical records that are created for a patient who is referred to the provider solely for a diagnostic evaluation shall not be subject to this section, if the provider does not provide treatment to the patient and reports the results of the diagnostic evaluation to the patient's referring provider.

<del>(d)</del>

(f) This section shall only apply to patient records created on and a health care provider, as defined in subdivision (a), who creates an initial patient record for a patient whose first visit with the health care provider occurs on or after January 1, 2009.

<del>(e)</del>

(g) This section shall not apply to patients who are minors a health care provider, as defined in subdivision (a), whose patient is a minor at the time the patient record is created.

<del>(f)</del>

(h) A health care provider who violates this section may be cited and assessed an administrative penalty in accordance with—this subdivision Section 125.9 of the Business and Professions Code.

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No citation shall be issued and no penalty shall be assessed upon the first violation by a licensee of this section. Upon the second 3 and each subsequent violation by a health care provider of this 4 section, a citation may be issued and an administrative penalty may be assessed after appropriate notice and opportunity for 5 hearings. Notwithstanding any other provision of law, the remedy 6 7 described in this subdivision constitutes the exclusive remedy for 8 a violation of this section. However, nothing in this section affects 9 other existing rights, duties, or remedies provided by law.

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(i) The patient records created by a psychiatrist, including psychotherapy notes, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations, are not subject to this section. For the purposes of this subdivision, "psychiatrist" means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act, who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.